park so Verlie established Searchlight Park, equipped with a new playground, grills, and picnic areas for the town.

These are a few of many visible contributions that Verlie made to the community, but Verlie's most important contributions exist outside of the public eye. She never asks for recognition and she does not draw attention to her actions, but her charity touches every person in need.

''She's always doing something for someone,'' said long time friend Marion Young. ''Verlie has a kindness for everyone and she'll never let someone go down the road hungry.''

Much of Verlie's philanthropy occurs behind the scenes, but her impact is felt throughout Searchlight. Each year, Verlie furnishes ice cream for ice cream socials. She has always supported the local police department, allowing the Searchlight Police to have Police Officer's Night Out. Verlie also provides a steak dinner annually for our firefighters and medical workers. Local children at the elementary school are treated to hamburgers at the Nugget for good grades. Anyone in need always comes to Verlie first, and she never turns them away.

Verlie means a lot to me personally. After my father's passing, Verlie was a close friend to my mother. She would take her to Las Vegas to shop, and looked after her because my mother lived in Searchlight alone. Her thoughtfulness and compassion helped my mother make it through tough and trying times. I will never be able to repay her kindness to my mother.

Verlie understands the importance of community. Her philanthropy—both visible and invisible—has made Searchlight the town it is today. Verlie Doing has touched every life in Searchlight, including my own, and I know that she has changed each life for the better.

Congratulations, Verlie. I am proud to honor an authentic Searchlight hero.

PUBLIC HEALTH SERVICE ACT

Mr. GRASSLEY. Mr. President, I want to take a few minutes to explain my recent action related to S. 1418, the Wired for Health Care Quality Act. Today, with great reluctance, I asked Leader FRIST to consult with us prior to any action related to consideration of this bill, which the Health, Education, Labor, and Pensions Committee reported by voice vote this morning.

The Wired for Health Care Quality Act would promote the use of electronic health records by adopting standards for the electronic exchange of information, offer incentives for health care providers to create networks for secure exchange of electronic health information, and ensure quality measurement and reporting of provider performance under the Public Health Service Act.

I fully support linking the adoption of health information technology to quality improvements in our health care system. They go hand in hand. Which is why Senator BAUCUS and I decided to introduce our Medicare Value Purchasing Act, S. 1356, jointly with Senators ENZI and KENNEDY's Better Healthcare Through Information Technology Act, S. 1355. The thought behind a dual introduction was to enforce the message that Medicare can drive quality improvement through payment incentives, and that the adoption of information technology is also a necessary step not only to facilitate the reporting of quality measures but also to increase efficiency and quality in our health care delivery system.

Our bill creates quality payments under Medicare for all provider groups. A considerable amount of time was devoted towards ensuring that the development of quality measures and the implementation of value-based purchasing programs under Medicare were properly vetted with provider groups, beneficiary groups, and the administration. We did not want to reinvent the wheel; we wanted to build on the initiatives that already exist to develop and adopt quality measures. And because Medicare is the single largest purchaser of health care in the Nation, adopting quality payments in Medicare influences the level of quality in all of health care. We have seen time and time again how when Medicare leads, the other public and private purchasers follow.

Which is why I am troubled, that as currently drafted, S. 1418 would require the development of quality measures under the Public Health Service Act. It is hard to comprehend how the quality measurement system in this bill intersects with the quality measurement system developed in the Medicare Value Purchasing Act. The last thing we want to do is end up with two different quality measurement systems. This has the potential to derail both proposals, effectively terminating or at least postponing the common goal of improving the quality of patient care.

The Wired for Health Care Quality Act would also direct the Secretary of Health and Human Services, along with the Secretary of Defense, the Secretary of Veterans Affairs, and other heads of relevant Federal agencies to jointly develop a quality measurement system. The coordination among all these Federal agencies alone is a massive project that could indefinitely stall the development and implementation of appropriate quality measures or result in one that falls to the lowest common denominator. That could actually set back quality efforts.

I welcome the opportunity to work with the sponsors of S. 1418, Senators ENZI, KENNEDY, FRIST, and CLINTON along with members of the Health, Education, Labor, and Pensions Committee on this matter. I had hoped to accomplish that before the bill was introduced on the floor. Unfortunately, that did not happen. I do not take actions such as these lightly. But I am deeply troubled that, as currently drafted, the Wired for Health Care Quality Act could end up unintentionally delaying our common goal of improving the quality of health care for all Americans.

Mr. BAUCUS. Mr. President, I rise to address possible floor consideration of S. 1418, a bill to amend the Public Health Service Act to enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the costs of health care in the United States.

Senator GRASSLEY and I have been working since January with Senators ENZI and KENNEDY on issues of quality and health information technology. Together, we introduced two bills on June 30—one that deals with Medicare quality, and another to enhance quality through the widespread adoption of health IT. The latter is S. 1356, the Medicare Value Purchasing Act of 2005, which develops a system of quality measurement and implements pay-for-performance in Medicare.

In drafting these two bills, we worked hard to craft language that was complementary rather than contradictory. Ultimately, we viewed these two pieces of policy as working together to build a comprehensive and workable health care quality system.

S. 1418 potentially disrupts the work we have done thus far, by including language that will force the duplication of quality measurement systems. It also raises questions about the jurisdictional reach of the Committee on Health, Education, Labor, and Pensions.

Medicare is the dominant payer in health care, with annual spending exceeding $300 billion. Furthermore, it is Medicare's payment systems that are often adopted by private insurance groups. Private payers use the Medicare physician fee schedule for their own book of business, and we would expect these same insurers to follow Medicare's lead on pay-for-quality.

I appreciate the process that Senators ENZI and KENNEDY have undertaken with us over the last several months. And I appreciate the majority leader's desire to move important health IT legislation. Congressional action on this issue is long overdue. But until common ground can be reached on a feasible system of measuring quality, I must reluctantly object to moving forward with S. 1418. I believe that the process outlined in this bill for the development of quality measures may well be unworkable and that it will raise deep concerns for hospitals, physicians, and other providers.

I also believe that the language on the development of quality measures in this bill ought to be designed for Public Health Service Act programs and explicitly applicable to these programs, not to Medicare or Medicaid.

I hope that our colleague, Senators ENZI, KENNEDY, FRIST, and CLINTON, will work with us to craft a bill that is appropriate for programs under the

PHSA and that complements the Medicare Value Purchasing Act of 2005. Ultimately, I believe that we have the same goals in mind. If we can come to an agreement now, we can continue moving forward with these important policies that can change the shape, quality, and ultimately the cost and benefit of our health care system.

METHAMPHETAMINE CRISIS

Mr. WYDEN. Mr. President, to draw attention to the meth crisis facing Oregon and a growing number of States around the country, I stand once again on the floor of the Senate introducing two more newspaper articles into the RECORD. Both articles highlight the plight of the most vulnerable victims of the meth crisis: America's children.

As the first piece, ''The Little Round Faces of Meth,'' from The Oregonian points out, ''The drug lurks behind nearly all of Oregon's most shocking and horrifying cases of child abuse and neglect.''

The second article, ''A Drug Scourge Creates Its Own Form of Orphan'' was printed in the New York Times a little over a week ago. As the article explains, ''In Oregon, 5,515 children entered the [foster care] system in 2004, up from 4,946 the year before, and officials there say the caseload would be half what it is now if the methamphetamine problem suddenly went away.''

The burden that meth is placing on Oregon communities is enormous. And we have to do something about it. Because even if we get the epidemic under control right now, we are going to be dealing with the consequences for years to come. And one of these consequences will be taking care of the child victims of meth. As Jay Wurscher, director of alcohol and drug services for the children and families division of the Oregon Department of Human Services explains in the New York Times article, ''In every way, shape and form, this is the worst drug ever for child welfare.''

We cannot afford to wait any longer. Each day we fail to act, another child is neglected, abused or even worse—dead—as a result of meth. I urge Congress to pass and the President to sign the Combat Meth bill, a solid step that will help us fight this terrible drug in Oregon and around the country. Among other things, the bill provides $5 million in grants to help kids affected by meth.

Mr. President, I ask for unanimous consent that the full text of The Oregonian article and the New York Times article be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From The Oregonian, July 9, 2005]

THE LITTLE ROUND FACES OF METH

You will have to imagine the face of a tearful 16-month-boy found toddling alone last Wednesday morning alongside River Road North in Keizer. You usually only see the faces of the child victims of methamphetamine, or learn their names, when they die.

The familiar faces of meth are the mug shots of the drug users and dealers spilling out of Oregon's jails and prisons. You have seen them so often in newspapers and on television newscasts that they have all but blurred into one gaunt face with hollow eyes, straggly hair, jack-o-lantern smiles.

But when a toddler winds up standing alone in a T-shirt and soiled diaper along a busy Oregon commuter street, while his parents apparently sleep off another night of drugs, it is time to realize the most awful thing about meth is not the rotten teeth it produces but the rotten parents.

That little boy in the diaper standing along River Road is among thousands of Oregon children who have suffered neglect and abuse linked to methamphetamine. State authorities say at least half of the investigated cases of abuse and neglect in Oregon trace back to the drug found in the apartment of the little boy's parents, Kurt Michael Quinn, 42, and Ivory Angela Williams, 26. The couple was arrested on multiple charges, including child neglect and possession of a controlled substance.

Of, course, meth was there. The drug lurks behind nearly all of Oregon's most shocking and horrifying cases of child abuse and neglect:

The parents who nailed a sheet of plywood over their baby's crib so that he would not escape while they were on a meth high.

The 10-month-old baby who crawled out of a two-story window and fell to the ground while his mother was strung out on meth.

The infant who died of an overdose from breast-feeding from a mother addicted to meth.

There was meth in the family of Ashton Parris, who died at 15 months from severe head injuries after the state returned him to his birth mother.

Jewell Newland was only 3-months-old when her meth-laden father, James Dean Newland, picked her up and then fell on her—with what the police affidavit called a ''whoof.'' Baby Jewell was bleeding from the mouth, but no one took her to the hospital for 14 long hours. She died of her injuries.

These are the little round faces of meth. They are the faces that demand the additional police, the tougher prison sentences, the expanded drug treatment and the hassle of a few extra minutes at the pharmacy waiting for the cold medicines that drug cookers turn into meth.

Yet, some still are not enlisted in this fight. Some oppose the tough international restrictions needed to control the ingredients in meth. Others want to weaken restrictions on cold medicines.

If only they all had a chance to pass River Road the other morning. If only they could see the face of that little boy toddling along in his T-shirt and diaper.

[From the New York Times, July 11, 2005]

A DRUG SCOURGE CREATES ITS OWN FORM OF ORPHAN

(By Kate Zernike)

The Laura Dester Shelter here is licensed for 38 children, but at times in the past months it has housed 90, forcing siblings to double up in cots. It is supposed to be a 24–hour stopping point between troubled homes and foster care, but with foster homes backed up, children are staying weeks and sometimes months, making it more orphanage than shelter, a cacophony of need.

In a rocking chair, a volunteer uses one arm to feed a 5–day-old boy taken from his mother at birth, the other to placate a toddler who is wandering from adult to adult begging, ''Bottle?'' A 3–year-old who arrived at dawn shrieks as salve is rubbed on her to kill the lice.

This is a problem methamphetamine has made, a scene increasingly familiar across the country as the number of foster children rises rapidly in states hit hard by the drug, the overwhelming number of them, officials say, taken from parents who were using or making methamphetamine.

Oklahoma last year became the first state to ban over-the-counter sales of cold medicines that contain the crucial ingredient needed to make methamphetamine. Even so, the number of foster children in the state is up 16 percent from a year ago. In Kentucky, the numbers are up 12 percent, or 753 children, with only seven new homes.

In Oregon, 5,515 children entered the system in 2004, up from 4,946 the year before, and officials there say the caseload would be half what it is now if the methamphetamine problem suddenly went away. In Tennessee, state officials recently began tracking the number of children brought in because of methamphetamine, and it rose to 700 in 2004 from 400 in 2003.

While foster populations in cities rose because of so-called crack babies in the 1990's, methamphetamine is mostly a rural phenomenon, and it has created virtual orphans in areas without social service networks to support them. In Muskogee, an hour's drive south of here, a group is raising money to convert an old church into a shelter because there are none.

Officials say methamphetamine's particularly potent and destructive nature and the way it is often made in the home conspire against child welfare unlike any other drug.

It has become harder to attract and keep foster parents because the children of methamphetamine arrive with so many behavioral problems; they may not get into their beds at night because they are so used to sleeping on the floor, and they may resist toilet training because they are used to wearing dirty diapers.

''We used to think, you give these kids a good home and lots of love and they'll be O.K.,'' said Esther Rider-Salem, the manager of Child Protective Services programs for the State of Oklahoma. ''This goes above and beyond anything we've seen.''

Although the methamphetamine problem has existed for years, state officials here and elsewhere say the number of foster children created by it has spiked in the last year or two as growing awareness of the drug problem has prompted more lab raids, and more citizens reporting suspected methamphetamine use.

Nationwide, the Drug Enforcement Administration says that over the last five years 15,000 children were found at laboratories where methamphetamine was made. But that number vastly understates the problem, federal officials say, because it does not include children whose parents use methamphetamine but do not make it and because it relies on state reporting, which can be spotty.

On July 5, the National Association of Counties reported that 40 percent of child welfare officials surveyed nationwide said that methamphetamine had caused a rise in the number of children removed from homes.

The percentage was far higher on the West Coast and in rural areas, where the drug has hit the hardest. Seventy-one percent of counties in California, 70 percent in Colorado and 69 percent in Minnesota reported an increase in the number of children removed from homes because of methamphetamine.

In North Dakota, 54 percent of counties reported a methamphetamine-related increase. At what was billed as a ''community meeting on meth'' in Fargo this year, the state attorney general, Wayne Stenehjem, exhorted the hundreds of people packed into an auditorium: ''People always ask, what can they do